GRADUATE STUDENT MC1

NANYANG TECHNOLOGICAL UNIVERSITY
PART I: CONFIDENTIAL MEDICAL HISTORY
(To be completed by the student)

Full Name (please underline surname): ______________________________

Sex: __________ NRIC / Passport no.: ______________________________ Date of Birth: ______________

Nationality: ______________________ Course of Study: ______________________________

Application no.: ______________________ Handphone no.: ______________________________

PERSONAL HISTORY	NO	YES	If Yes, give details & dates
1. NERVOUS SYSTEM/PSYCHIATRY Frequent headaches, migraine, giddiness, fainting spells, epilepsy (fits), nervous breakdown, anxiety disorder, depression, phobias, substance dependency, eating disorder, treated by psychiatrist before			
2. EYE, EAR, NOSE, THROAT History of seeing black spots, bright lights, blur vision, hearing problems, ear infection, hearing loud noises (tinnitus), constant running nose, sneezing, blocked nose, nose bleeding			
3. RESPIRATORY SYSTEM Asthma, frequent cough, tuberculosis, shortness of breath on and off			
4. CARDIOVASCULAR SYSTEM Chest pain, palpitations, high blood pressure, heart murmur			
5. GASTROINTESTINAL SYSTEM Gastric problem, frequent diarrhoea, constipation problem, stomach ulcer, abdominal pain on and off, bloatedness, piles (haemorrhoids)			
6. GENITAL-URINARY SYSTEM Sugar, protein or blood in urine, urinary tract infection, kidney problem, testicular lumps (males only), hernia, sexually-transmitted infections			
7. ENDOCRINE SYSTEM Thyroid problem, diabetes			
8. MUSCULO-SKELETAL SYSTEM Frequent backache, knee pain on and off, frequent ankle sprains, neck problem, shoulder problem, gout, previous fracture			
9. SKIN Eczema, urticaria, fungal infection, psoriasis			
10. Any serious injuries, hospitalisation, operation?			
11. Are you a Hepatitis B carrier?			
12. Any disability, impairment or special needs, or illness / condition not mentioned above?			
13. FOR LADIES ONLY History of breast lump, irregular menses, severe menstrual pain etc			

FAMILY HISTORY	No	Yes	If Yes, give details
1. Hypertension			
2. Heart Disease			
3. Stroke			
4. Diabetes			
5. Tuberculosis			
6. Mental Disorder			
7. Others			

SOCIAL HISTORY	No	Yes	If Yes, give details
1. Cigarettes			No. of cigarettes/day: No. of years smoked:
2. Alcohol			
DRUG HISTORY	No	Yes	
1. Drugs taken presently			
2. Allergy			

Data Protection Information

Your health records are held in confidence by the NTU University Health Service. Your school will be informed if there is a need to make adjustments for you if it is relevant to your educational needs or if it affects the safety of the people you work with. You may obtain access to your health record by contacting the NTU University Health Service.

Declaration

I hereby declare that I have not withheld any relevant information or made any misleading statement. I consent to my information being held and processed by the NTU University Health Service as described in the 'Data Protection Information' above.

Student's Signature: ______________________________ Date: ______________________

GRADUATE STUDENT

NANYANG TECHNOLOGICAL UNIVERSITY
PART II: REPORT OF MEDICAL EXAMINATION
(To be completed by a Registered Physician)

SIGNIFICANT MEDICAL HISTORY (including psychiatric disorders):

PHYSICAL EXAMINATION:

Height: ___________ m Weight: ________ kg Vision: ____________________ Colour Vision: ________________________

Blood Pressure: ___________________________________ Pulse Rate: _______________________________________

Cardiovascular System:

Respiratory System:

Abdomen (Note presence of hernia):

Central Nervous System:

Musculoskeletal System:

Others:

INVESTIGATION:

Urine:- Protein: _________________ Sugar: _________________ Blood: _________________ Others: _________________

Hepatitis B surface Antigen:_________________ Hepatitis B surface Antibody:____

Chest X-ray Report (should have been made within last six months, and film should be attached to the report):

OTHERS:

Is patient now under treatment for any physical/emotional condition:

Do you have any recommendation regarding the care of this student:

Any drug allergy:

I certify that I have this day examined the abovenamed and the results of medical examination are as set forth. In my opinion, he/she is found to be in good health and free from any physical defect, organic or nervous ailments or after effects thereof which might render him/her unfit to pursue or complete his/her university course of studies.

________________________________ ____ ________________
Physician's Signature Name & Professional Qualifications Date

Clinic Address: